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U.S. | PAYING TILL IT HURTS : Surprise Bills

## After Surgery, Surprise \$117,000 Medical Bill From Doctor He Didn't Know

By ELISABETH ROSENTHAL SEPT. 20, 2014

Before his three-hour neck surgery for herniated disks in December, Peter Drier, 37, signed a pile of consent forms. A bank technology manager who had researched his insurance coverage, Mr. Drier was prepared when the bills started arriving: \$56,000 from Lenox Hill Hospital in Manhattan, \$4,300 from the anesthesiologist and even \$133,000 from his orthopedist, who he knew would accept a fraction of that fee.

He was blindsided, though, by a bill of about \$117,000 from an “assistant surgeon,” a Queens-based neurosurgeon whom Mr. Drier did not recall meeting.

“I thought I understood the risks,” Mr. Drier, who lives in New York City, said later. “But this was just so wrong — I had no choice and no negotiating power.”

In operating rooms and on hospital wards across the country, physicians and other health providers typically help one another in patient care. But in an increasingly common practice that some medical experts call drive-by doctoring, assistants, consultants and other hospital employees are charging patients or their insurers hefty fees. They may be called in when the need for them is questionable. And patients usually do not realize they have been involved or are charging until the bill arrives.

The practice increases revenue for physicians and other health care workers at a time when insurers are cutting down reimbursement for many services. The surprise charges can be especially significant because, as in Mr. Drier's case, they may involve out-of-network providers who bill 20 to 40 times the usual local rates and often collect the full amount, or a substantial portion.

“The notion is you can make end runs around price controls by increasing the number of things you do and bill for,” said Dr. Darshak Sanghavi, a health policy expert at the Brookings Institution until recently. This contributes to the nation's

\$2.8 trillion in annual health costs.

Insurers, saying the surprise charges have proliferated, have filed lawsuits challenging them. In recent years, unexpected out-of-network charges have become the top complaint to the New York State agency that regulates insurance companies. Multiple state health insurance commissioners have tried to limit patients' liability, but lobbying by the health care industry sometimes stymies their efforts.

"This has gotten really bad, and it's wrong," said James J. Donelon, the Republican insurance commissioner of Louisiana. "But when you try to address it as a policy maker, you run into a hornet's nest of financial interests."

In Mr. Drier's case, the primary surgeon, Dr. Nathaniel L. Tindel, had said he would accept a negotiated fee determined through Mr. Drier's insurance company, which ended up being about \$6,200. (Mr. Drier had to pay \$3,000 of that to meet his deductible.) But the assistant, Dr. Harrison T. Mu, was out of network and sent the \$117,000 bill. Insurance experts say surgeons and assistants sometimes share proceeds from operations, but Dr. Tindel's office says he and Dr. Mu do not. Dr. Mu's office did not respond to requests for comment.

The phenomenon can take many forms. In some instances, a patient may be lying on a gurney in the emergency room or in a hospital bed, unaware that all of the people in white coats or scrubs who turn up at the bedside will charge for their services. At times, a fully trained physician is called in when a resident or a nurse, who would not charge, would have sufficed. Services that were once included in the daily hospital rate are now often provided by contractors, and even many emergency rooms are staffed by out-of-network physicians who bill separately.

Patricia Kaufman's bills after a recent back operation at a Long Island hospital were rife with such charges, said her husband, Alan, who spent days sorting them out. Two plastic surgeons billed more than \$250,000 to sew up the incision, a task done by a resident during previous operations for Ms. Kaufman's chronic neurological condition.

In the days after the operation, "a parade of doctors came by saying, 'How are you,' and they could be out of network or in network," Mr. Kaufman said. "And then you get their bills. Who called them? Who are they?"

Doctors' offices often pursue patients for payment. Ms. Kaufman's insurer paid about \$10,000 to the plastic surgeons, who then sent a bill for the remainder. The couple, of Highland Park, N.J., refused to pay.

When insurers intervene in a particular case, they say they have limited ability to fight back. Insurance examiners “are not in the room on the day of surgery to see the second surgeon walk into the room or why they were needed,” said Clare Krusing, a spokeswoman for America’s Health Insurance Plans, an industry group. And current laws do not require hospitals that join an insurance network to provide in-network doctors, labs or X-rays, for example.

So sometimes insurers just pay — to protect their customers, they say — which encourages the practice. When Mr. Drier complained to his insurer, Anthem Blue Cross Blue Shield, that he should not have to pay the out-of-network assistant surgeon, Anthem agreed it was not his responsibility. Instead, the company cut a check to Dr. Mu for \$116,862, the full amount.

## Unexpected Fees

When Mr. Drier agreed to surgery in December, he was not in a good position to bargain or shop around. Several weeks earlier, he had woken up to excruciating pain in his upper back and numbness and weakness in two fingers of his left hand, which persisted. A scan showed that one of the disks that normally serve as cushions between vertebrae was herniated and pushing on a nerve. With a busy job and social life, he was living on painkillers.

The rate of spinal surgery in the United States is about twice that in Europe and Canada, and five times that in Britain, said Dr. Richard A. Deyo of Oregon Health and Science University, who studies international comparisons. Studies are limited but have generally concluded that after two years, patients who have surgery for disk problems do no better than those treated with painkillers and physical therapy — although the pain, which can be debilitating, resolves far more rapidly with surgery.

The United States has more neurosurgeons per capita than almost any other developed country, and they compete with orthopedists for spinal surgery. At the same time, Medicare and private insurers have reduced payments to surgeons. The average base salary for neurosurgeons decreased to \$590,000 in 2014 from \$630,000 in 2010, according to Merritt Hawkins, a physician staffing firm.

To counter that trend, some spinal surgeons have turned to consultants —

including a Long Island company called Business Dynamics RCM and a subsidiary, the Business of Spine — that offer advice on how to increase revenue through “innovative” coding, claim generation and collection services.

Some strategies used by surgeons, including billing large amounts for a second surgeon in the room or declaring an operation an emergency, raise serious questions. The indications for immediate spinal surgery, such as loss of bladder function or rapidly progressive paralysis, are rare. But insurers are more likely to reimburse a hospital or surgeon with whom they do not have a contract if a case is labeled an emergency.

Mark Sullivan, 46, of New Jersey, went to an emergency room last year with excruciating lower back pain and leg weakness. He was in the operating room less than 24 hours later. “The surgeon stood at the foot of my bed and said, ‘You need surgery; you won’t walk out of the hospital,’ ” he recalled.

Mr. Sullivan’s emergency admission made it easier for an out-of-network surgeon to perform the operation and bill \$29,000. The insurer paid \$9,500, and Mr. Sullivan paid about \$580, as required by his plan. When the doctor’s billing office pursued Mr. Sullivan for the balance of the bill and even threatened to turn his account over to collection, he agreed to file an appeal with his insurer for additional payment, but he refused to pay more himself.

## A Last-Minute Surprise

Mr. Drier’s concern about extra charges began even during his preoperative physical. The hospital sent his blood tests to an out-of-network lab and required him to have an echocardiogram (eventually billed for \$950), even though he had no cardiac history. (The American Society of Echocardiography discourages such testing for patients with no known heart problems.)

His worries escalated as he lay prepped for the operating room on the morning of his surgery. A technician from a company called Intraoperative Monitoring Service L.L.C. asked him to sign a financial consent form, noting that the company did not accept Blue Cross Blue Shield plans, so he would be required to pay the bill himself. The monitoring had been ordered by his surgeon and is considered essential for the

type of neurosurgery he was having, to make sure delicate nerves are not damaged as they are manipulated.

"I demanded to know the price, and when he said he didn't know, I made him call," Mr. Drier recalled. When the technician said it would be \$500 plus an hourly rate, Mr. Drier negotiated it down to \$300.

In the operating room, he underwent a procedure called spinal fusion, in which the surgeons removed two herniated disks that were impinging on nerves, and inserted some bone graft as well as plates and screws to stabilize the spine. On his hospital bill, Mr. Drier noted charges for three implants, a total of about \$10,400, as well as for two surgical screws billed at \$2,470 and \$3,990 — expensive for hardware, he thought, but his insurer paid the full amount.

The biggest surprise was the bill from Dr. Mu, the assistant surgeon. Fusions generally require a second trained pair of hands, but those can be provided by a resident or a neurosurgical nurse or physician assistant employed by the hospital, for whom there is no additional charge. The operative record for Mr. Drier's surgery states that no qualified resident was available.

Dr. Mu is the chief of neurosurgery at Jamaica Hospital Medical Center in Queens, though he sometimes operates at other hospitals. According to a database that tracks hospital admissions in New York State, most operations he performs at Jamaica involve emergency surgery on Medicaid patients, often victims of trauma — a challenging but probably not very lucrative practice.

One insurer, Aetna, is in court with Dr. Mu's private-practice group, NeuroAxis Neurosurgical Associates of Kew Gardens, Queens. NeuroAxis sued to recover higher payments for its out-of-network assistant surgeons; Aetna says the practice's fees for those surgeons are excessive. J. Edward Neugebauer, chief litigation officer at Aetna, said the company had also sued an in-network neurosurgeon on Long Island who always called in an out-of-network partner to assist, resulting in huge charges. The surgeons shared a business address.

Surgeons from other specialties also team up: After Gunther Steinberg of Portola Valley, Calif., had a needle biopsy of an eye lesion in 2010, he discovered that his insurer had paid about \$10,000 to the eye surgeon who performed the outpatient procedure and \$10,700 to a second ophthalmologist in the room.

"The idea of having an assistant in the O.R. has become an opportunity to make up for surgical fees that have been slashed," said Dr. Abeel A. Mangi, a professor of

cardiac surgery at Yale, who said the practice had become commonplace. "There's now a whole cadre of people out there who do not have meaningful appointments as attending surgeons, so they do assistant work."

In Mr. Drier's case, each surgeon billed for each step of the procedure. Dr. Tindel billed \$74,000 for removing two disks and an additional \$50,000 for placing the hardware that stabilized Mr. Drier's spine. Dr. Mu billed \$67,000 and \$50,000 for those tasks.

If the surgery had been for a Medicare patient, the assistant would have been permitted to bill only 16 percent of the primary surgeon's fee. With current Medicare rates, that would have been about \$800, less than 1 percent of what Dr. Mu was paid.

## Visitors Who Bill

Unexpected fees are routinely generated outside the operating room as well. On the wards, a dermatologist may be called in to examine a rash and perform an expensive biopsy. The person in scrubs who walks a patient to a bathroom for the first time after hip surgery may turn out to be a physical therapist billing \$400.

Mr. Sullivan, who had the emergency back surgery, discovered charges from more than 10 providers in the 48 hours after his operation. (The surgery involved simply trimming a herniated disk in his lower back.) He wrote to various doctors to dispute bills, saying, "I was admitted to Overlook Hospital from Nov. 26-27, 2013, and I have received numerous invoices for procedures that were never done, by physicians that never treated me."

He was puzzled by \$679 in occupational therapy charges involving the delivery of a device to help him put on his socks, which he never used. He was irate about charges from a group of hospital-based primary care physicians from Inpatient Medical Associates, who visited him briefly once a day and billed close to \$1,000 in out-of-network costs.

Healthy surgical patients typically do not need a general doctor; an anesthesiologist clears them for surgery. Mr. Sullivan noted that if he had needed an internist, he would have called his own, who is in his insurance network and whose office is just down the block.

Dr. Mangi, the Yale cardiac surgeon, said hospitals often encouraged extra visits for both billing and legal reasons. He said he was required to request a physical therapy consult before each discharge, for example, even if he felt there was no need.

"You can cut fees, but institutions find ways" to make the money back, he said. "There's been a mushrooming industry of mandatory consultants for services that neither doctors nor patients want."

## A Possible Remedy

For months, Mr. Drier stewed over what to do with the \$117,000 check Anthem Blue Cross had sent him to pass on to Dr. Mu, refusing to sign over a payment he considered "outrageous and immoral." He worried that such payments could drive up premiums at his employer.

In the past few years, some insurers have filed lawsuits and sought injunctions to prevent providers from going after their clients for payment of unexpected medical bills. Dr. Scott Breidbart, chief medical officer at Empire Blue Cross Blue Shield, part of the same parent company that covers Mr. Drier, said that it had not taken that route, but that in some situations it had refused to do further business with in-network surgeons who repeatedly called in out-of-network assistants.

A New York State law that will take effect in March — one of a few nationally — will offer some protection against many surprise charges and require more advance disclosure from doctors and hospitals on whether their services are covered by insurance. It states, for example, that patients are not responsible for unforeseen out-of-network charges beyond what they would have paid in-network. It directs insurers and hospitals to negotiate any further payment or enter mediation.

In many other countries, such as Australia — where, as in the United States, people often rely on private insurance — it is seen as a patient's right to be informed of out-of-pocket costs before hospitalization, said Mark Hall, a law professor at Wake Forest University.

Mr. Drier tried to negotiate with the surgeons to divvy up the \$117,000 payment in a way he believed was more fair; he liked Dr. Tindel and felt he was being underpaid. Mr. Drier's idea, he wrote in an email, was to settle on "a reasonable fee

for both the surgeon and assistant and return the rest of the check to the insurance company/employees" of his company.

But in July, he received a threatening letter from Dr. Mu's lawyer noting that he had failed to forward the \$117,000 check. So he sent it along, with regret.

For a continuing conversation about health care costs and pricing in the United States, please join our Facebook group, [Paying Till It Hurts](#).

A version of this article appears in print on September 21, 2014, on page A1 of the New York edition with the headline: After Surgery, \$117,000 Bill for Doctor He Didn't Know.

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## READERS' PERSPECTIVES How you and others responded

### QUESTIONS

Have you experienced surprise medical charges that you learned of only when you received a bill or an insurance statement? Please share your story. 1105

### FILTERS

All

Uninsured

## Have you experienced surprise medical charges that you learned of only when you received a bill or an insurance statement? Please share your story.

1105 READER RESPONSES

**Trevor S** Los angeles, United States Insured

This happened to me several years ago.. To this day the whole situation infuriates me. I voluntary went to the emergency room to get 6 stitches from a biking incident. They called an orthopedic specialist in. He was out of network and the final bill was 15k. My insurance covered the first \$2,500. After 9 months of negotiations, I settled for \$2,500 on the \$12,500 remaining. I didn't know he was out of network and had no idea that the bill would be so high. This is a common loophole and needs to be addressed urgently.

**Concerned Health Consumer** NY, United States Insured

I went to an ER on a Sunday afternoon not knowing that it was a huge mistake! I did not realize that my non-life threatening red rash (which turned out to be an insect bite would cost me close to \$1000 -\$700+ for room' \$300 for the PA. I was not confined in the ER -- the room was used for consultation and blood test. I was shocked by the cost of the PA. The billing group explained that the cost is based on service, not the person who sees you.